TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-1834-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pursuant to *RULE §134.204 of the Medical Fee Guide line (j)(A)(3)(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.* This examination concluded that the injured employee had not reached Maximum Medical Improvement and therefore, was billed with the correct modifier of (NM) 'not met'."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor, selected by the treating doctor, on 3/10/15 determined the claimant was not at MMI … A designated doctor on 9/3/15 concluded the claimant reached MMI on 8/8/15 with a 1% impairment rating … The designated doctor's evaluation was the first evaluation of maximum medical improvement and impairment. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2015	Referral Doctor Examination to Determine Maximum Medical Improvement and Impairment Rating	$350.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed service?
3. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. The requestor is seeking reimbursement of $350.00 for an examination to determine if the injured employee had reached maximum medical improvement and, if so, the impairment rating, represented by procedure code 99456-NM. The insurance carrier denied disputed services with claim adjustment reason code 892 – "DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS."

   Regarding an examination to determine maximum medical improvement, 28 Texas Administrative Code §134.204(j)(3) states, in relevant part.

   (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier…
   (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:
      (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,
      (ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection.
   (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

   Further, 28 Texas Administrative Code §134.204(j)(2)(A) states,

   > If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

   Review of the submitted information finds that the requestor billed the disputed service in accordance with 28 Texas Administrative Code §134.204. The insurance carrier's denial reason is not supported.

2. Review of the submitted documentation finds that the requestor was a referral doctor that had not previously treated the injured employee and performed an examination to determine maximum medical improvement. Therefore, the MAR for this service is $350.00, in accordance with 28 Texas Administrative Code §134.204(j)(3)(C).

3. The total MAR for the disputed service is $350.00. The insurance carrier paid $0.00. A reimbursement of $350.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	April 14, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.